**NHS North East Essex CCG Primary Care Ophthalmic Services**

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**Referral Form** NHS No:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Mr/Mrs/Miss **Patient** | **GP** | **Referring Clinician** |
| Last Name |  |  |  |
| First Name |  |
| Address |  |  |
|  |  |
|  |  |
| Postcode |  |  |
| Phone and Fax |  |  |
| Date of Birth |  | Professional Reg No. |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Referral to:** | **Glaucoma Refinement Service** | **OPSI** **Refinement Service** | **Secondary Care** | **For GP Information** |
| **Urgency:**  | 🞏 Routine | 🞏 Urgent | 🞏 Emergency |
| **Clinic Required** | 🞏 Cataract | 🞏 Glaucoma | 🞏 Paediatric Ophthalmology |
| 🞏 Cornea/Contacts | 🞏 Low Vision | 🞏 Diabetic/Medical Retina |
| 🞏 External Eye Disease | 🞏 Ocular Motility/sqint | 🞏 Vitreo Retinal |
| 🞏 YAG Laser | 🞏 Oculoplastic/Lacrimal | 🞏 General Ophthalmology |
|  | Sph | Cyl | Axis | VA | Pin Hole | IOP | 🞏 NCT🞏 GAT🞏 Perkins |
| R |  | - |  |  |  |  |
| L |  | - |  |  |  |  |
|  |
| **Visual Fields**: 🞏 Normal 🞏 Abnormal |
| **C.D. Ratio:**  |
| **Findings:adf** |
| **Diagnosis:\dad****Diagnosis By** (*Please Circle)***:** Optometrist/OPSI Refinement Service/Glaucoma Refinement Service/GP  |
| The patients consent to information being exchanged between clinicians has been obtained: 🞏 |
| **Referring Clinicians Signature: Date:** |

|  |
| --- |
| **GP Action:** |
| **Attachments including**: 🞏 Medications and relevant history 🞏 Visual Fields  |

V1. February 2014